CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF PODIATRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE TO PRACTICE PODIATRIC MEDICINE
INSTRUCTION SHEET

Selecting Type of Application

The application asks you to select the type of application you are filing. The two types of application are *Direct Application* and *Reciprocity*. Which you choose depends on whether you are *currently* licensed in another jurisdiction (state, U.S. territory or District of Columbia) and, if so, whether any of the jurisdictions has licensure requirements substantially similar to those of Delaware.

Select **Direct Application** if *either* of these situations applies to you:

- You recently completed your residency year and are ***not*** licensed in another jurisdiction, ***or***
- You hold a current license in another jurisdiction(s) but you have ***not*** practiced podiatric medicine *at least* five years ***and none*** of the jurisdictions where you are currently licensed has licensure requirements that are substantially similar to those of Delaware.

Select **Reciprocity** if you are *currently* licensed in another jurisdiction ***and*** *either* of these situations applies to you:

- A jurisdiction where you are currently licensed has licensure requirements that are substantially similar to those of Delaware, ***or***
- You have practiced podiatric medicine *at least* five years in a jurisdiction where you are currently licensed even though the jurisdiction does not have licensure requirements substantially similar to Delaware's.

To compare the licensure requirements of a jurisdiction where you are currently licensed to those of Delaware, see Section 4.2 of the Board's Rules and Regulations.

If you select Reciprocity, the Board will compare the licensure requirements of each jurisdiction where you hold a current license to those of Delaware. If the Board determines that ***none*** of the jurisdictions has substantially similar requirements ***and*** you have ***not*** practiced podiatric medicine for five years, you would be required to meet the requirements for licensure by Direct Application because you cannot be licensed by Reciprocity.

Requirements for *All* Applicants

These requirements apply regardless of whether you apply by Direct Application or Reciprocity.

☐ Submit a completed, signed, notarized *Application for Licensure to Practice Podiatric Medicine*.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."

☐ Arrange for the Board office to receive an official transcript sent *directly* from your school of podiatric medicine to Board office.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ Request a self-query from the National Practitioner Data Banks (NPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the ***original report*** to the Board office.

☐ Arrange for the Board office to receive verification of licensure from *each* jurisdiction in which you hold, or have *ever* held, a license to practice podiatric medicine, sent *directly* from the jurisdiction to the Board office.
- If applying by Reciprocity, you must hold a *current* license in at least one of these jurisdictions.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirements for *Direct Applicants*

If you select Direct Application, the following requirements apply in addition to those listed in **Requirements for All Applicants** above:

☐ Submit a certificate or equivalent proof that you have completed your residency.

☐ Arrange for the Board office to receive score reports sent *directly* from the following exam services:
- For scores on the American Podiatric Medical Licensing Examinations (APMLE) Parts I and II, see www.nbpme.org.
- For scores on the APMLE Part III, see www.fpmb.org.

Additional Requirements for *Reciprocity* Applicants

If you select Reciprocity, the following requirements apply in addition to those listed in **Requirements for All Applicants** above: To be licensed by Reciprocity without five years of practice, at least one jurisdiction where you are currently licensed must have licensure requirements substantially similar to Delaware's requirements. However, if you have practiced podiatric medicine for at least five years, it is not necessary for a jurisdiction where you are currently licensed to have licensure requirements substantially similar to Delaware's requirements.

☐ Provide copies of the current Podiatry laws and rules/regulations from each jurisdiction where you are currently licensed.

☐ If you have practiced podiatric medicine for at least five years, submit proof of five years of practice.
- For periods of employment, arrange for your employers to submit *Verification of Employment* forms directly to the Board office.
- For periods of self-employment, submit copies of tax forms or business licenses.

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APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one). The Instruction Sheet explains these types.

   ☐ Direct Licensure

   ☐ Reciprocity – I hold a *current* license in these jurisdictions: _____

   If you are applying by *Reciprocity*, submit current copies of Podiatry statutes and rules and regulations from each jurisdiction listed above.

IDENTIFYING AND CONTACT INFORMATION

2. Name: _____ _____ _____
   Last/Family First Middle

3. Other Names Used: _____ _____ _____

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:** _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Address: _____
   Street

   _____ _____ _____
   City State Zip Code

7. Day Phone: _____ Email: _____

EDUCATION AND EXAMINATIONS

8. Enter the following information about the institution where you received your DPM:

   Name: _____ Date of Degree: _____

   Address: _____

   Arrange for your school to send an official transcript *directly* to the Board office.

9. Enter the following information about your residency:

   Hospital Name: _____

   Address: _____

   Director: _____ Attendance Dates:_____ _____
   From To

   If applying by *Direct Application*, submit a certificate or other proof of completing your residency.

10. Enter the requested information about your exams:

If applying by *Direct Application*, arrange for the Board office to receive score reports sent *directly* from the exam service.

EXAMINATION	SCORE	EXAM DATE
APMLE Part I		
APMLE Part II		
APMLE Part III		

LICENSURE AND PRACTICE HISTORY

11. Have you ever been granted a podiatric license by any jurisdiction (state, U.S. territory or D.C.)? Yes ☐ No ☐ If yes, complete the following for all licenses. Use a separate sheet if necessary.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (current or expired)

Arrange for the Board office to receive a license verification from *each* jurisdiction listed above, sent *directly* from the jurisdiction to the Board office.

12. Have you ever held any other healthcare license? Yes ☐ No ☐ If yes, enter the following information about *each* license:

TYPE OF LICENSE	JURISDICTION	HAS THIS LICENSE BEEN DISCIPLINED?	IF DISCIPLINED, EXPLAIN:
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	

13. Enter the following information about the locations and dates of your practice. *Include military service.*

EMPLOYER/ PRACTICE NAME	ADDRESS WHERE PRACTICED	NATURE OF PRACTICE	EMPLOYMENT DATES

If you are applying by *Reciprocity* and no jurisdiction where are you are currently licensed has substantially similar requirements to those of Delaware, you must document at least five years of practice after licensure. For periods of employment, arrange for your employer(s) to send *Verification of Employment* forms directly to the Board office. For periods of self-employment, submit tax forms or business licenses for the periods.

14. List hospital staff affiliations and duration. Attach additional sheets if needed.

HOSPITAL NAME	COMPLETE ADDRESS	SERVICE DATES

DISCLOSURES

15. Have you ever been *denied* a podiatric or other healthcare license by any jurisdiction? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Include the license type, jurisdiction, and the reason for each denial.**

16. Have you received any administrative penalties regarding your practice of podiatry in any jurisdictions – such as fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations – or have you been a party to a consent agreement containing conditions placed by a board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

17. Have you ever had a podiatric license revoked, suspended, limited, or placed on probation? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

18. Have you ever had a disciplinary action taken against you by a Podiatric Medical Society? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

19. Has a hospital ever changed your privileges as a result of a disciplinary action? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

20. Are any charges or complaints pending against you in any jurisdiction, or are you currently under investigation for unprofessional conduct, professional misconduct, or malpractice? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

21. Have you ever been denied a narcotic license (controlled substance registration) or had such license modified, restricted, suspended, canceled, or revoked, or have you ever prescribed narcotic drugs unlawfully? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

22. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, the Drug Enforcement Agency of the Department of Justice, or any state's Narcotic Agency in this country or any other country? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents**.

23. Have you ever:
    - Engaged in the practice of podiatric medicine without a license? Yes ☐ No ☐
    - Employed or knowingly cooperated in fraud or material deception to acquire a podiatric license? Yes ☐ No ☐
    - Impersonated another person holding a podiatric license? Yes ☐ No ☐
    - Allowed another person to use your podiatric license? Yes ☐ No ☐
    - Aided or abetted anyone not licensed as a podiatrist to represent him or herself as a podiatrist? Yes ☐ No ☐

    If yes to any one of the above, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

24. Have you ever entered into a settlement, or had a verdict rendered against you, in a malpractice action? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

25. Are you now, or within the last three years have you been, dependent on the use of alcohol, stimulants, or habit-forming drugs or alcohol or been treated or disciplined for their use? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

26. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper.

27. Are you currently physically and mentally *capable* of practicing podiatric medicine and surgery according to generally accepted standards? Yes ☐ No ☐ If no, continue with the next question. If yes, skip to the DUTY TO REPORT section.

28. Do you agree to submit to an examination to determine such capability as the Board may deem necessary? Yes ☐ No ☐

DUTY TO REPORT

29. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

30. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

31. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your podiatrist license in another jurisdiction has been subject to discipline or has been surrendered, suspended or revoked.

    I certify that I have read and understand 24 *Del. C.* §515 (a)(9) and that I understand my *duty to self report*. Yes ☐ No ☐

To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

Signature: _____ Date: _____

State of _____ County of _____

The above applicant, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this _____ day of _____, 2_____

Signature of Notary Public: _____

SEAL

My commission expires on _____

APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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EMPLOYMENT VERIFICATION FORM

INSTRUCTIONS

Applicants for Delaware podiatric licensure by reciprocity must arrange for the Board to receive documentation of five years of practice after licensure if the jurisdiction where they are licensed does not have licensure requirements that are substantially similar to those of Delaware (Section 4.4 of the Board's Rules and Regulations). The purpose of this form is to document periods of podiatric employment in such jurisdictions.

Applicant: Complete the Authorization for Release of Information section and provide the form to the employer who will verify your employment.

Employer: Complete the *Employment Information* section. Sign the form in the presence of a notary. ***Mail*** the completed, signed, notarized form ***directly*** to the Board of Podiatry at address above. Forms returned by the applicant will not be accepted. Faxed forms will not be accepted.

APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

Complete and sign this release. Send a copy to each employer.

Applicant Name: _____ Social Security Number: _____

I authorize release of information about my podiatric employment to the Delaware Board of Podiatry.

Applicant Signature: _____ Date: _____

EMPLOYMENT INFORMATION

Complete and sign in the presence of notary. Mail the form directly to the Board office at the address above. Only forms mailed directly from the employer will be accepted. Forms returned by the applicant will not be accepted. Faxed forms will not be accepted.

1. Name of Practice Where Applicant Employed: _____
2. Mailing Address: _____
   _____
3. Phone: _____ Email: _____
4. The employee named above worked at this practice from _____ (Start Date) to _____ (End Date)
5. This employment was in the State of _____.

Signature of Employer Representative: _____ Date: _____

Printed Name: _____ Title: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, in the year _____

Notary Signature: _____

SEAL

My Commission expires: _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

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